		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039230

Facility Name: OTTAWA PAVILION

Address: 800 E. CENTER ST. (Number) OTTAWA (City) 61350 (Zip Code)

County: LASALLE

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3919766001

Date of Initial License for Current Owners: 12/01/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,435	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,333	4,333	8
9	SNF/PED					9
10	ICF	20,083	8,309	389	28,781	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,083	8,309	4,722	33,114	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.24%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 4,333

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	192,904	19,334	4,044	216,282		216,282		216,282			1
2	Food Purchase		160,162		160,162		160,162	(2,317)	157,845			2
3	Housekeeping	122,766	21,862		144,628		144,628		144,628			3
4	Laundry	39,913	12,869	2,698	55,480		55,480		55,480			4
5	Heat and Other Utilities			98,563	98,563		98,563	725	99,288			5
6	Maintenance	37,690	34,207	10,531	82,428		82,428	8,078	90,506			6
7	Other (specify):*			7,104	7,104		7,104	482	7,586			7
8	**TOTAL General Services**	393,273	248,434	122,940	764,647		764,647	6,968	771,615			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,474,707	64,354	39,739	1,578,800		1,578,800	(402)	1,578,398			10
10a	Therapy	133,423	285	4,290	137,998		137,998	(77)	137,921			10a
11	Activities	80,041	4,599	3,173	87,813		87,813		87,813			11
12	Social Services	32,056		3,451	35,507		35,507		35,507			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,720,227	69,238	56,653	1,846,118		1,846,118	(479)	1,845,639			16
	C. General Administration											
17	Administrative	48,856		213,600	262,456		262,456	(102,891)	159,565			17
18	Directors Fees											18
19	Professional Services			30,162	30,162		30,162	4,203	34,365			19
20	Dues, Fees, Subscriptions & Promotions			19,743	19,743		19,743	(6,903)	12,840			20
21	Clerical & General Office Expenses	52,951	20,478	98,037	171,466		171,466	(40,970)	130,496			21
22	Employee Benefits & Payroll Taxes			439,299	439,299		439,299	72	439,371			22
23	Inservice Training & Education			2,315	2,315		2,315		2,315			23
24	Travel and Seminar							193	193			24
25	Other Admin. Staff Transportation			3,615	3,615		3,615		3,615			25
26	Insurance-Prop.Liab.Malpractice			109,115	109,115		109,115	2,386	111,501			26
27	Other (specify):*							15,498	15,498			27
28	**TOTAL General Administration**	101,807	20,478	915,886	1,038,171		1,038,171	(128,412)	909,759			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,215,307	338,150	1,095,479	3,648,936		3,648,936	(121,923)	3,527,013			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OTTAWA PAVILION #0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			31,779	31,779		31,779	116,384	148,163			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			55,207	55,207		55,207	302,601	357,808			32
33	Real Estate Taxes			51,521	51,521		51,521	2,108	53,629			33
34	Rent-Facility & Grounds			388,000	388,000		388,000	(388,000)				34
35	Rent-Equipment & Vehicles			12,256	12,256		12,256	6,166	18,422			35
36	Other (specify):*											36
37	**TOTAL Ownership**			538,763	538,763		538,763	39,259	578,022			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,936	71,083	175,019		175,019	(1,852)	173,167			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		103,936	136,236	240,172		240,172	(1,852)	238,320			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,215,307	442,086	1,770,478	4,427,871		4,427,871	(84,516)	4,343,355			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,880)	30		9
10	Interest and Other Investment Income	(287)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,273)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,044)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(22,949)	21		18
19	Entertainment		20		19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(7,145)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	869			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (37,959)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(46,557)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (46,557)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (84,516)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OTTAWA PAVILION

ID# 0039230

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 869	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	869		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,317)	0	0	0	0	0	0	0	0	0	0	(2,317)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	725	0	0	0	0	0	0	0	0	725	5
6	Maintenance	869	0	2,221	4,988	0	0	0	0	0	0	0	8,078	6
7	Other (specify):*	0	0	58	0	424	0	0	0	0	0	0	482	7
8	**TOTAL General Services**	(1,448)	0	3,004	4,988	424	0	0	0	0	0	0	6,968	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(402)	0	0	0	0	0	(402)	10
10a	Therapy	0	0	0	0	0	(77)	0	0	0	0	0	(77)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(479)	0	0	0	0	0	(479)	16
	C. General Administration													
17	Administrative	0	(213,600)	0	110,709	0	0	0	0	0	0	0	(102,891)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,750	1,473	0	0	(20)	0	0	0	0	0	4,203	19
20	Fees, Subscriptions & Promotions	(7,395)	0	492	0	0	0	0	0	0	0	0	(6,903)	20
21	Clerical & General Office Expenses	(22,949)	(51,400)	28,889	4,490	0	0	0	0	0	0	0	(40,970)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	72	0	0	0	0	0	72	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	193	0	0	0	0	0	0	0	0	193	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,386	0	0	0	0	0	0	0	0	2,386	26
27	Other (specify):*	0	0	4,965	0	10,533	0	0	0	0	0	0	15,498	27
28	**TOTAL General Administration**	(30,344)	(262,250)	38,398	115,199	10,533	52	0	0	0	0	0	(128,412)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,792)	(262,250)	41,402	120,187	10,957	(427)	0	0	0	0	0	(121,923)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OTTAWA PAVILION # 0039230 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(5,880)	118,994	3,270	0	0	0	0	0	0	0	0	116,384	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(287)	300,011	2,877	0	0	0	0	0	0	0	0	302,601	32
33	Real Estate Taxes	0	0	2,108	0	0	0	0	0	0	0	0	2,108	33
34	Rent-Facility & Grounds	0	(388,000)	0	0	0	0	0	0	0	0	0	(388,000)	34
35	Rent-Equipment & Vehicles	0	0	6,166	0	0	0	0	0	0	0	0	6,166	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,167)	31,005	14,421	0	0	0	0	0	0	0	0	39,259	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(1,852)	0	0	0	0	0	(1,852)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	(1,852)	0	0	0	0	0	(1,852)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(37,959)	(231,245)	55,823	120,187	10,957	(2,279)	0	0	0	0	0	(84,516)	45

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATACHED		SCHEDULE ATTACHED	SCHEDULE ATTACHED			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 213,600	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (213,600)	1
2	V	21	BOOKKEEPING FEES	51,400	" " "			(51,400)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V	34	RENT	388,000	OTTAWA PAVILION BUILDING LLC			(388,000)	10
11	V	30	DEPRECIATION		" " "		118,994	118,994	11
12	V	32	INTEREST		" " "		300,011	300,011	12
13	V	19	PROFESSIONAL FEES		" " "		2,750	2,750	13
14	Total			$ 653,000			$ 421,755	$ * (231,245)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 725	$ 725	15
16	V	6	REPAIR & MAINT.		" " "	100.00%	2,221	2,221	16
17	V	7	EMP. BEN. - GEN. SERVICES		" " "	100.00%	58	58	17
18	V	19	PROFESSIONAL FEES		" " "	100.00%	1,473	1,473	18
19	V	20	DUES AND SUBSCRIPTION		" " "	100.00%	492	492	19
20	V	21	CLERICAL & GENERAL		" " "	100.00%	28,889	28,889	20
21	V	24	SEMINARS AND TRAVEL		" " "	100.00%	193	193	21
22	V	26	INSURANCE		" " "	100.00%	2,386	2,386	22
23	V	27	EMP. BEN. - GEN. ADMIN.		" " "	100.00%	4,965	4,965	23
24	V	30	DEPRECIATION		" " "	100.00%	3,270	3,270	24
25	V	32	INTEREST		" " "	100.00%	2,877	2,877	25
26	V	33	REAL ESTATE TAXES		" " "	100.00%	2,108	2,108	26
27	V	35	EQUIPMENT RENTAL		" " "	100.00%	6,166	6,166	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 55,823	$ * 55,823	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 4,988	$ 4,988	15
16	V	10	NURSING CMP. - SUE G.		" " "	100.00%			16
17	V	17	ADMIN. CMP. - M. MAUER		" " "	100.00%	27,868	27,868	17
18	V	17	ADMIN. CMP. - M. AARON		" " "	100.00%	41,235	41,235	18
19	V	17	ADMIN. CMP. - F. AARON		" " "	100.00%			19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN. CMP. - S. KOPLIN		" " "	100.00%	7,912	7,912	21
22	V	17	ADMIN. CMP. - D. MAGAFAS		" " "	100.00%			22
23	V	17	ADMIN. CMP. - E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP. - S. BOGEN		" " "	100.00%	9,611	9,611	24
25	V	17	ADMIN. CMP. - S. LEVY		" " "	100.00%	10,781	10,781	25
26	V	17	ADMIN. CMP. - HOWARD ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP. - NON-OWNER		" " "	100.00%	13,302	13,302	27
28	V	21	CLERICAL. CMP. - S. AARON		" " "	100.00%	4,490	4,490	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 120,187	$ * 120,187	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 424	$ 424	15
16	V	15	EMP. BEN. - SUE G.		" " "	100.00%			16
17	V	27	EMP.BEN. - M. MAUER		" " "	100.00%	1,211	1,211	17
18	V	27	EMP. BEN. - M. AARON		" " "	100.00%	1,545	1,545	18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%			19
20	V	27	EMP. BEN. - S. GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN. - S. KOPLIN		" " "	100.00%	2,504	2,504	21
22	V	27	EMP. BEN. - D. MAGAFAS		" " "	100.00%			22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%	891	891	24
25	V	27	EMP. BEN. - S. LEVY		" " "	100.00%	1,556	1,556	25
26	V	27	EMP. BEN. - H. ALTER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	1,983	1,983	27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	843	843	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 10,957	$ * 10,957	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$ 4,290	DYNAMIC REHAB CONSULTANTS LLC		$ 4,213	$ (77)	15
16	V	19	PROFESSIONAL FEES	1,100	" " "		1,080	(20)	16
17	V	22	EMPLOYEE BENEFITS	(4,014)	" " "		(3,942)	72	17
18	V	39	ANCILLARY SERVICES	65,387	" " "		64,213	(1,174)	18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	2,788	LINCOLN MEDICAL SUPPLIES, INC.		2,386	(402)	21
22	V	39	ANCILLARY EXPENSE	4,704	" " "		4,026	(678)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,255			$ 71,976	$ * (2,279)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	MAURY AARON		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	$ 41,235	17-7	1
2	MARSHALL MAUER		ADMINISTRATIVE					SALARY	27,868	17-7	2
3	SHEILA BOGEN		ADMINISTRATIVE					SALARY	9,611	17-7	3
4	SHARON AARON		CLERICAL					SALARY	4,490	21-7	4
5	DENNIS NEHMER		MAINTENANCE					SALARY	4,988	6-7	5
6	SUSAN KOPLIN HARAMARAS		ADMINISTRATIVE					SALARY	4,912	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 93,104		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	441,841	13	$ 9,671	$	33,114	$ 725	1
2	6	REPAIR & MAINT.	" "	441,841	13	29,636	3,380	33,114	2,221	2
3	7	EMP. BEN. - GEN. SERVICES	" "	441,841	13	778		33,114	58	3
4	19	PROFESSIONAL FEES	" "	441,841	13	19,651		33,114	1,473	4
5	20	DUES AND SUBSCRIPTION	" "	441,841	13	6,566		33,114	492	5
6	21	CLERICAL & GENERAL	" "	441,841	13	385,463	300,175	33,114	28,889	6
7	24	SEMINARS AND TRAVEL	" "	441,841	13	2,576		33,114	193	7
8	26	INSURANCE	" "	441,841	13	31,835		33,114	2,386	8
9	27	EMP. BEN. - GEN. ADMIN.	" "	441,841	13	66,254		33,114	4,965	9
10	30	DEPRECIATION	" "	441,841	13	43,634		33,114	3,270	10
11	32	INTEREST	" "	441,841	13	38,384		33,114	2,877	11
12	33	REAL ESTATE TAXES	" "	441,841	13	28,121		33,114	2,108	12
13	35	EQUIPMENT RENTAL	" "	441,841	13	82,269		33,114	6,166	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 744,838	$ 303,555		$ 55,823	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	10	$ 59,032	$ 59,032	3	$ 4,988	1
2	10	NURSING CMP. - SUE G.	" "	40	1	32,744	32,744			2
3	17	ADMIN. CMP. - M. MAUER	" "	40	12	363,103	363,103	3	27,868	3
4	17	ADMIN. CMP. - M. AARON	" "	40	10	487,988	487,988	3	41,235	4
5	17	ADMIN. CMP. - F. AARON	" "	45	6	193,312	193,312			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	" "	37	2	153,497	153,497			6
7	17	ADMIN. CMP. - S. KOPLIN	" "	40	8	71,542	71,542	4	7,912	7
8	17	ADMIN. CMP. - D. MAGAFAS	" "	45	9	87,437	87,437			8
9	17	ADMIN. CMP. - E. CASSON	" "	38	1	31,246	31,246			9
10	17	ADMIN. CMP. - S. BOGEN	" "	45	2	54,060	54,060	8	9,611	10
11	17	ADMIN. CMP. - S. LEVY	" "	45	12	140,632	140,632	3	10,781	11
12	17	ADMIN. CMP. - HOWARD ALTER	" "	40	1	12,000	12,000			12
13	17	ADMIN. CMP. - NON-OWNER	" "	45	12	157,563	157,563	4	13,302	13
14	21	ADMIN. CMP. - S. AARON	" "	40	12	58,502	58,502	3	4,490	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,902,658	$ 1,902,658		$ 120,187	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG. HOURS	40	10	$ 5,020	$	3	$ 424	1
2	15	EMP. BEN. - SUE G.	" "	40	1	3,128				2
3	27	EMP. BEN. - M. MAUER	" "	40	12	15,782		3	1,211	3
4	27	EMP. BEN. - M. AARON	" "	40	10	18,288		3	1,545	4
5	27	EMP. BEN. - F. AARON	" "	45	6	28,556				5
6	27	EMP. BEN. - S. GOLDSTEIN	" "	37	2	25,672				6
7	27	EMP. BEN. - S. KOPLIN	" "	40	8	22,644		4	2,504	7
8	27	EMP. BEN. - D. MAGAFAS	" "	45	9	12,125				8
9	27	EMP. BEN. - E. CASSON	" "	38	1	3,418				9
10	27	EMP. BEN. - S. BOGEN	" "	45	2	5,010		8	891	10
11	27	EMP. BEN. - S. LEVY	" "	45	12	20,299		3	1,556	11
12	27	EMP. BEN. - H. ALTER	" "	40	1	1,296				12
13	27	EMP. BEN. - NON-OWNER	" "	45	12	23,491		4	1,983	13
14	27	EMP. BEN. - S. AARON	" "	40	12	10,982		3	843	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 195,711	$		$ 10,957	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						4,213	2
3	19	PROFESSIONAL FEES	" "						1,080	3
4	22	EMPLOYEE BENEFITS	" "						(3,942)	4
5	39	ANCILLARY SERVICES	" "						64,213	5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						2,386	9
10	39	ANCILLARY EXPENSE	" "						4,026	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 71,976	25

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HAJEK/REICHERT		X	MORTGAGE	$36,043.00	12/01/98	$ 3,800,000	$ 3,543,090	12/18	9.7500	$ 300,011	1
2												2
3	SHAREHOLDERS	X		WORKING CAPITAL			200,500	200,500			7,519	3
4	INTERCOMPANY	X		WORKING CAPITAL			350,000	350,000			24,504	4
5	COMPASS		X	VAN	$444.00	10/27/02	13,563	12,812	10/05	3.9900	95	5
	Working Capital											
6	MANUFACTURERS BANK		X	WORKING CAPITAL			450,000	450,000		PRIME+	19,766	6
7			X	INSURANCE			109,115	26,165			3,323	7
8	RELATED PARTY	X									2,877	8
9	TOTAL Facility Related				$36,487.00		$ 4,923,178	$ 4,582,567			$ 358,095	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,923,178	$ 4,582,567			$ 358,095	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 51,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 50,521	2
3. Under or (over) accrual (line 2 minus line 1).		$ (479)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 51,521	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	49,954	8
	1998	50,028	9
	1999	49,910	10
	2000	50,378	11
	2001	50,521	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OTTAWA PAVILION COUNTY LASALLE

FACILITY IDPH LICENSE NUMBER 0039230

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-13-111-001	NURSING HOME	$ 50,521.00	$ 50,521.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,521.00	$ 50,521.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 45,128 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1998	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	119		1998		$ 3,243,000	$ 83,151	39	$ 83,151	$	$ 336,074	4
5											5
6											6
7											7
8					33,246	852	35	950	98	8,865	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1994	13,015	333	39	333		2,810	9
10	WALLPAPER			1995	18,314	470	39	470		3,403	10
11	DRYWALL IN CORRIDOR			1995	17,550	450	39	450		3,281	11
12	HANDRAILS			1995	7,839	201	39	201		1,449	12
13	SECURITY DOOR			1995	1,602	41	39	41		289	13
14	MIXING VALVE & WATER HEATER			1995	756	19	39	19		134	14
15	HANDRAIL & BUMPER			1996	6,895	177	39	177		1,232	15
16	HANDRAIL & BUMPER			1996	721	18	39	18		120	16
17	ALARM			1996	1,146	29	39	29		186	17
18	PANIC DEVICE			1996	1,550	40	39	40		248	18
19	REPLACE RECONNECT SWITCH & STARTER			1996	1,074	28	39	28		171	19
20	DRAPERIES			1996	13,334	342	39	342		2,066	20
21	DRAPERY, CARPETING			1997	12,786	328	39	328		1,710	21
22	PIPING WORK, HEAT/COOL UNITS			1997	4,341	111	39	111		583	22
23	HEAT/COOL UNITS			1998	4,732	131	39	131		593	23
24	OFFICE REMODELING			1998	1,475	38	39	38		173	24
25	SHELVING/COOLER			1998	1,493	28	39	28		135	25
26	BOILER, HEAT/COOL UNIT			1999	10,441	268	39	268		1,041	26
27	ALARM SYSTEM			1999	2,853	73	39	73		289	27
28	WINDOWS			1999	19,785	507	39	507		1,823	28
29	FOLDING STEEL GATE			1999	884	23	39	23		70	29
30	REMODELING DISHWASHER ROOM			1999	5,000	128	39	128		389	30
31	DRAPERIES			1999	6,439	165	39	165		529	31
32	PARKING LOT PAVING			1999	1,834	47	39	47		168	32
33	BASEMENT REMODEL			2000	15,203	553	27.5	553		1,296	33
34	WINDOW REPAIR -- DOOR			2000	3,026	110	27.5	110		257	34
35	FEED PUMP -- HOT WATER VALVE			2000	4,131	150	27.5	150		353	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SPRINKLER SYSTEM REPAIR	2000	$ 1,175	$ 43	27.5	$ 43	$	$ 101	37
38	AIR CONDITIONER	2000	1,273	46	27.5	46		108	38
39	CARPETING -- SHEERS	2000	5,693	996	20	285	(711)	1,821	39
40	BASEMENT REMODEL	2001	20,088	733	27.5	733		1,077	40
41	BIOLER/SPRINKLER REPAIRS	2001	10,031	365	27.5	365		538	41
42	BOILER REPAIR/PUMP/COMPRESSOR	2002	11,888	151	27.5	151		151	42
43	HEATER	2002	2,938	16	27.5	16		16	43
44	BASEMENT REMODEL	2002	18,705	317	27.5	317		317	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,526,256	$ 91,478		$ 90,865	$ (613)	$ 373,866	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 157,763	$ 10,501	$ 14,235	$ 3,734	10	$ 72,164	71
72	Current Year Purchases	30,808	11,090	1,540	(9,550)	10	1,540	72
73	Fully Depreciated Assets							73
74	RELATED PARTY	376,744	37,071	37,404	333	10	333,598	74
75	TOTALS	$ 565,315	$ 58,662	$ 53,179	$ (5,483)		$ 407,302	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	FACILITY	1999 DODGE RAM VAN	2002	13,563	2,713	2,713		5	2,713	77
78	RELATED PARTY			4,219	1,190	1,406	216		2,927	78
79										79
80	TOTALS			$ 17,782	$ 3,903	$ 4,119	$ 216		$ 5,640	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,509,353	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 154,043	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 148,163	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (5,880)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 786,808	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 7,081 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	1999 DODGE RAM VAN	$ 575.00	$ 5,175	17
18					18
19					19
20					20
21	TOTAL		$ 575.00	$ 5,175	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 17,228	$		$ 17,228	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				11,720			11,720	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				36,441			36,441	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					89,776		89,776	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): LAB & SUPPLIES	39-2						19,854		19,854	13
14	TOTAL				$		$ 65,389	$ 109,630		$ 175,019	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	619,022		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,933		6
7	Other Prepaid Expenses	2,172		7
8	Accounts Receivable (owners or related parties)	38,032		8
9	Other(specify): RE TAX ESCROW	50,503		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 754,662	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	250,010		15
16	Equipment, at Historical Cost	202,134		16
17	Accumulated Depreciation (book methods)	(169,339)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SECURITY DEPOSIT	153,860		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 436,665	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,191,327	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 262,982	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	462,812		29
30	Accrued Salaries Payable	198,290		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,012		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,000		32
33	Accrued Interest Payable	4,960		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 991,056	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	550,500		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 550,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,541,556	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (350,229)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,191,327	$	48

*(See instructions.)

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (467,048)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (467,048)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(171,180)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PAID IN CAPITAL	288,000	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 116,820	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (350,229)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,151,543	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,151,543	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	103,588	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 103,588	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	287	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 287	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT EARNED	1,273	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,273	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,256,691	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	764,647	31
32	Health Care	1,846,118	32
33	General Administration	1,038,171	33
	B. Capital Expense		
34	Ownership	538,763	34
	C. Ancillary Expense		
35	Special Cost Centers	175,019	35
36	Provider Participation Fee	65,153	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,427,871	40
41	**Income before Income Taxes (line 30 minus line 40)****	(171,180)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (171,180)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,829	2,095	$ 46,090	$ 22.00	1
2	Assistant Director of Nursing	1,783	1,827	47,033	25.74	2
3	Registered Nurses	16,524	17,770	363,782	20.47	3
4	Licensed Practical Nurses	11,879	12,893	214,035	16.60	4
5	Nurse Aides & Orderlies	70,316	75,315	767,018	10.18	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,561	4,996	133,423	26.71	8
9	Activity Director	1,941	2,198	24,395	11.10	9
10	Activity Assistants	7,254	7,940	55,646	7.01	10
11	Social Service Workers	3,236	3,541	32,056	9.05	11
12	Dietician					12
13	Food Service Supervisor	2,099	2,301	35,773	15.55	13
14	Head Cook	1,001	860	9,097	10.58	14
15	Cook Helpers/Assistants	18,084	18,828	148,034	7.86	15
16	Dishwashers					16
17	Maintenance Workers	3,406	3,532	37,690	10.67	17
18	Housekeepers	16,246	17,668	122,766	6.95	18
19	Laundry	5,195	5,700	39,913	7.00	19
20	Administrator	1,789	2,124	48,856	23.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,263	4,523	52,951	11.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,084	3,513	36,749	10.46	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,490	187,624	$ 2,215,307 *	$ 11.81	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	166	$ 4,044	1-3	35
36	Medical Director	120	6,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	48	2,648	10-3	38
39	Pharmacist Consultant	116	4,640	10-3	39
40	Physical Therapy Consultant	50	2,750	10a-3	40
41	Occupational Therapy Consultant	28	1,540	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	70	3,173	11-3	44
45	Social Service Consultant	63	3,451	12-3	45
46	Other(specify) PSYCHIATRIC	45	2,014	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	706	$ 30,260		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	674	24,736	10-3	51
52	Nurse Aides	214	5,701	10-3	52
53	TOTAL (lines 50 - 52)	888	$ 30,437		53

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
MARGIE LYLE	ADMIN	0	$ 48,856
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 48,856

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 213,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 213,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK BOKOR KAGDA	ACCOUNTING	$ 10,438
FROST RUTTENBERG	ACCOUNTING	5,515
SACHNOFF & WEAVER	LEGAL	5,967
ECONOCARE	PURCHASING CONSLT	2,142
HEALTH DATA SYSTEMS	DATA PROCESSING	3,854
PERSONNEL PLANNERS	UC CONSULTANT	1,146
DYNAMIC REHAB CONSULT	DATA PROCESSING	1,100
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 30,162

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,234
Unemployment Compensation Insurance	29,962
FICA Taxes	169,184
Employee Health Insurance	160,267
Employee Meals	#REF!
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	8,652
EMPLOYEE BENEFITS - RELATED PARTY	72
TOTAL (agree to Schedule V, line 22, col.8)	$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,527
Health Care Worker Background Check	1,296
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	7,145
TRUST/FRANCHISE/CONTRIB/ETC	250
LICENSES & PERMITS	407
DUES & SUBSCRIPTIONS	7,118
MGMT CO ALLOCATION	492
TRUST/FRANCHISE/CONTRIB/ETC	(250)
Less: Public Relations Expense	(0)
Non-allowable advertising	(7,145)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,840

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	193
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 193

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	2000	$ 2,607	3	$	$ 434	$ 869	$ 869	$ 435	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,607		$	$ 434	$ 869	$ 869	$ 435	$	$	$	$

Facility Name & ID Number OTTAWA PAVILION # 0039230 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC. $6,904.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 9,531 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 65,153
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? NA Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: OTTAWA PAVILION **#0039230** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	4,044	
	REPAIRS & MAINTENANCE		0	
			0	4,044
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,698	
			0	2,698
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		33,193	
	ELECTRICITY		50,465	
	WATER		14,922	
	CABLE TV - LOBBY		(17)	
			0	98,563
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		900	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,565	
	ELEVATOR MAINTENANCE & REPAIR		4,465	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,601	
	FIRE SERVICE		0	
			0	
			0	
			0	10,531
7	**OTHER**			
	SCAVENGER		7,104	
	SECURITY SERVICE		0	7,104
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	6,000	6,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	30,437	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,640	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B 46-2	2,014	
	RN CONSULTANT	XVIII B 38-2	2,648	
			0	
			0	39,739
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,750	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,540	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	4,290
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,173	
			0	3,173
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,451	
			0	3,451
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OTTAWA PAVILION **#0039230** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	213,600	213,600
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	3,854	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	26,308	
			0	30,162
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,145	
	EMPLOYEE WANT ADS	XIX F	3,527	
	CONTRIBUTIONS	VI 20 XIX F	250	
	DUES & SUBSCRIPTIONS	XIX F	7,118	
	LICENSES & PERMITS	XIX F	407	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,296	19,743
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)			
	EQUIPMENT REPAIR & MAINTENANCE		9,570	
	OUTSIDE CLERICAL SERVICES		51,400	
	PENALTIES / OVERDRAFT CHARGES	VI 18	22,949	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		14,118	
	MESSENGER SERVICE		0	
			0	98,037

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	169,184	
	UNEMPLOYMENT COMPENSATION	XIX D	29,962	
	WORKERS COMPENSATION INSURANC	XIX D	71,234	
	HOSPITALIZATION INSURANCE	XIX D	160,267	
	EMPLOYEE BENEFITS - OTHER	XIX D	8,652	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	439,299
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,315	2,315
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,615	3,615
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		109,115	109,115
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,095,479